OES Independent Support Services RFP, #200804210
Questions from Mollie Baldwin, Home Care for Maine
Submitted May 28, 2008

1. **There are two dates cited for the due date of the proposal-on page 7 the date states July 17, 2008 and on page ten the date is July 22, 2008. Which date is correct?**
   The correct date is July 22. We apologize for the inconsistency.

2. **Will the FY dates of October to September rather than the state FY dates be maintained going forward? In Appendix A, state fiscal year is defined and is typically July 1 to June 30.**
   The fiscal year will coincide with the state fiscal year, beginning July 1, 2009. The successful bidder(s) will have a contract from 10/1/08 – 6/30/09, and continue on a state fiscal year thereafter.

3. **In Table I there is reference to a district funding formula moving to reflect 2010 population of people aged 55+. Does this mean that the rules to be adopted will limit services to those 55 years plus? If so what happens to the current population being served across the state under the age of 55? Will these consumers be discharged from the program? If not discharged, how are applicants to consider those under age 55 into the population figures for each district?**
   Consumers under the age of 55 will continue to be served, consistent with the current rules. The 55+ population group was chosen, because it represents the largest portion of consumers receiving this service.

4. **Has income distribution been considered in allocation of the funds in Table I?**

The formula used to allocate funds is based on the projected numbers of individuals by county, over 55, with any IADL or ADL with income below 200% of the federal poverty level, as provided by the Muskie Institute and the recent Long Term Care Needs Assessment.

5. **Does the estimated $2,500,000 include co-payments or is this amount all state funds?**
   This is the amount of state funds.

6. **Does distribution of funds by the district population eliminate the premise of first come, first served and can it be expected this will change in the new rules to be adopted?**
   This does not eliminate the first come, first served premise and at this time we do not anticipate changes in the rules.

7. **Eligibility determination: The narrative states that the initial assessment will be done by the assessing services agency and then handed off to the provider in the district who will then determine financial eligibility. Does this mean that functional eligibility only will be determined initially by the assessing services agency? If the provider agency determines a consumer does not meet the financial eligibility criteria the provider agency must issue an ineligible notice-correct?**

   Functional eligibility is determined by the Assessing Services Agency at the initial assessment and by the provider on subsequent assessments. Financial eligibility is verified by the provider after the initial assessment, prior to the start of services. They also verify if a person is requesting a waiver of copay. If the person does not meet financial eligibility as determined by the provider, then a notice will need to be given. A person would get a 60 day appeal right since they were not yet open to services and services that had not started could not continue.

   Demand for Services: Will the new rules provide the authority for providers to determine prioritization of clients' needs when insufficient funds are available to serve all those eligible? How will there be consistency on who gets services across multiple providers if there is more than one successful bidder? Does what a consumer receives for services when determined eligible depend on location and that district's prioritization plan? Will Section 40 language be revised to allow this level of provider discretion?
   The provider will maintain a wait list and services will be provided on a first come first served basis.
   Providers have the authority to determine the hours of service in the service plan. The OES seeks information on how the bidder(s) will efficientlly provide these service units. Example: providing 4 hours every 2 weeks vs. 2 hours weekly when appropriate.

8. **Supply of Services: What items will be included in determination that a provider meets 95% of authorized capacity? What is included in 95% of authorized capacity? Will missed delivery of visits no longer be acceptable when clients have conflicts and will clients risk the transfer of funds to other districts because they have canceled visits and the 95% is not met? Will adjustments be considered for suspension of services due to hospital admissions? Will adjustments be considered for canceled visits by consumers due to their illness or other appointments? Will adjustments be made for weather conditions or illness of workers? Will the financial adjustment to be made for not meeting the 95% be a redistribution of funds to other districts or disencumbrance of funds for other programs? If funds are reallocated to another district or provider will initial assessments on new consumers be suspended until funds are available in that district?**
   If consumers are considered to be on the program (see questions 40 and 41 in the list of questions from the bidders conference), they are included in this determination.

9. **Co-Payment- Financial adjustments will be made monthly to account for additional revenue collected from co-payments. To what source will adjustment be made- the 1/12th monthly cash allocation request?**
   Yes, it will be made to the 1/12th monthly cash allocation request.
10. **How will applicants know the numbers served by the current three providers by district? Since not all current recipients have been assessed how will the number of consumers served be determined for transition from another provider to the successful bidder?**
    Current consumers served by Catholic Charities Maine and Community Health and Counseling will be assessed by the assessing services agency to determine eligibility. Consumer totals may change after the assessments are complete, but as of April, Catholic Charities Maine serves 281, Community Health and Counseling Services serves 91 and Home Care for Maine serves 1,855.

11. **Will current consumers served by other providers who have not been assessed by the assessing services agency be assessed under Section 69 rules before being transferred to the successful bidder?**
    Yes.

12. **Will access to the State's automated assessing system MeCare be provided? If the reassessments are done on paper will the expectation be that all assessments if completed on paper will be forwarded to OES as stated in the eligibility determination section under background? Will completion of the entire MED form be required for reassessments completed by providers?**
    Access to the State's MeCare system has not yet been determined due to issues of confidentiality. It has not yet been determined if the paper copies of the reassessments will be forwarded to OES. An abbreviated version of the MED form will be required for reassessments. The OES will work with successful bidder(s) to determine the most efficient and accurate methods of reassessments and reporting.

13. **Section (L) - This language implies there will be the opportunity to transition consumers over a timeframe and at a cost as planned by the successful bidder. Does this mean there will be funds and transition period available to allow transfer of consumers to the successful bidders and from current providers in a timely organized fashion?**
    There will be no additional funds available. OES will work with the successful bidder(s) to transition consumers.

14. **Scope of work questions**:
    Coordinating Functions

1. (2). Conduct annual reassessments- How will the reassessments be completed, manually on paper MED form or via MeCare?

The pertinent pages of the MED form will be used for reassessments, and the OES will work with successful bidder(s) to determine the most efficient and accurate methods of reassessments.

2. (5). (should be 4) Establish a waiting list: Please explain the 14 day timeframe, is this counted from the date of referral, the date of assessment, date of the start of eligibility or the date that the provider receives the complete assessment from the assessing services agency?

Placement on waitlist begins when the provider receives the complete assessment from the assessing services agency.

If the waiting list is formed based on the county specified in district funding, is the provider forbidden from utilizing funds available in one county to serve consumers in another county within the district?

No, funds specified for a specific district may be used to serve all consumers within that district.

How about utilizing funds unspent between districts based on the number of consumers on the waiting list? If funds are unspent in one district does this mean a waiting list is still formed for the district in which the consumer resides?

Yes, however, if successful bidder(s) receive more than one district, and significant discrepancies occur between the bidder(s) districts, upon consultation with the OES, the OES may allow the agency to use funds designated for one district to serve consumers in another district.

What is the expectation and interpretation of updating waiting lists quarterly-what does this include as action steps?

OES is seeking to improve the accuracy of the waiting list and updating it quarterly will provide more accurate information. The bidder(s) have responsibility for presenting a plan on how to accomplish this. For example, the bidder(s) may decide to phone individuals on the wait list quarterly to determine if they still require and request the service.

Does OES expect to see monthly the number of hours authorized based on the assessment outcome or based on the service plan developed by the provider?

The OES expects to see the monthly number based on the service plan developed by the provider.

When a waiting list is in place, for what period of time will the assessment outcome be considered valid?

If a person has had an advisory assessment within the last year and the consumer is considered eligible, they can receive services until the date of their next reassessment.

If the assessment outcome is no longer valid who will assess the consumer again since no services have yet been provided?

The provider will reassess with the modified MED version, based on the original assessment information and the consumer's current status.

Currently OES receives the number of consumers on the waiting list by county. Under monthly reporting requirements it states listing consumers on the waiting list-does this mean listing by name or the total number of consumers waiting by county?

Please submit by name and county.

3. **Page 25 –opening paragraph states in the last sentence:**
   Submit the following reports to OES no later than ten days after the end of the month This requirement depends on the payroll cycle for the provider agency. For example in June, HCM will not have received timesheets from workers for the dates of June 29th and 30th until July 14, 2008. The timesheets have to be verified and processed. The earliest an accurate report of hours delivered for the time period of June 1 to June 30 would be available from HCM is July 21, not making the ten day requirement. Is OES willing to be flexible on this requirement when the payroll schedule of any provider determines how soon the end of the month hours are available?
   Yes

4. **Under Section (G) Training - Will OES provide training on administration of the MED tool to assure consistency and transfer of knowledge and philosophy regarding the assessment tool? This language requests that the provider identify who will train staff on the administration of the MED tool.**
   Yes

5. **Under Section (M) Costs and billing - The language states that the consumer names will not be submitted, but may be requested as part of the auditing process (page 23). Then on page 25 Monthly service reports including active client lists implies listing of all active clients. Please clarify the requirement.**
   The names are not needed for costs and billing purposes. Names are required for monthly service reports.

Limitations

1. **Each recipient of Independent Support Services may receive…… up to maximum of 10 hours per month. In number 6 in the prior section is a statement "assure costs ….. do not exceed the applicable annual number of hours……. Please confirm that 120 hours is currently the maximum number of hours that can be received annually by an individual consumer.**
   The answer is in OES Policy Section 69.03 (A).

2. **Please help find the rule citation to backup the statement that for reimbursement to continue without interruption beyond the approved classification period, the agency must perform the reassessment and submit it to OES at least 30 days prior to the termination date of the approved classification.**

   Based on past practice, the assessment will be effective for the 12-month period, with the reassessment taking effect at the termination of the last assessment. The reassessment may occur within 30 days of the expiration of the previous assessment.

3. **Does this mean that a consumer has to be assessed in the 11th month of service because OES must receive the reassessment at least 30 days prior to the last day of current eligibility?**
   No.

   Will consumers due for reassessment in September or October have an extension of their eligibility granted until the reassessment can be completed? Does OES want to receive copies of all reassessments prior to the end date of current eligibility?
   These details can be discussed with the successful bidder(s).

   Rulemaking and training - Is there anyway if there are rule changes that OES provide training prior to October 1, 2008? If transition must be completed by the start of the agreement and the consumers have not all been assessed per current rules will the successful bidder be required to determine financial or functional eligibility per the rules?
   Training can be provided as soon as the rules are promulgated.

   Appendix A: Will the definition of Assessing Services agency be modified to include that the successful bidder/provider also has the authority to determine eligibility and the authorization of services under Section 69 after the initial determination?
   Yes.

Are self-directed workers included in the definition of sub vendor?
Please refer to the definition in Appendix A, on page 5.

Is there any reason a sub vendor included in one proposal and that same sub vendor be submitting a bid for a one or all districts?
An organization may submit a bid for one or all districts and also be included in a proposal with another organization.